The courts' role in decisions about medical treatment

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Each year there are about 20 cases in the family division of the High Court in England and Wales concerning whether medical procedures should be carried out on people who are unable, or refuse, to consent to such treatment. This article examines how and why these cases need to, and do, go to court.

There are three types of cases, those in which:

- Medical opinion is that a particular course of treatment will save life—this includes whether blood transfusion should be given, a caesarean section should be performed, or even a heart transplant should be ordered against the known views of the patient
- Medical opinion is that consistently with the duty owed to the patient an aspect of treatment should be terminated so as to allow that patient to die peaceably— this centres round the termination of artificial feeding and hydration for patients in permanent vegetative states
- Those caring for a patient, supported by medical opinion, wish for a particular operation to be carried out to enhance the quality of life of the patient or to ensure improvement or prevent deterioration in his or her physical or mental health—this most commonly concerns whether sterilisation of a patient who is unable to consent should be carried out.

In legal proceedings I am brought in as a state funded lawyer to represent those who need a guardian ad litem or litigation friend (primarily children and mentally incapacitated people), or I may be asked by the court to assist as an amicus. The history of my office can be traced back to mediaeval times when the state first recognised the need for representation of an incapacitated person when a benevolent relative or friend could not be found to act on his or her behalf. The cases concerning medical treatment, of much more recent origin, take up a small but important part of my workload. I have a counterpart in Belfast who performs the same role there. In Scotland there is no equivalent institution, and this article should not be read as applying to the law, practices, and procedures in that quite separate jurisdiction.

Summary points

Circumstances occur in which it is necessary or wise to obtain authority from a court as to the lawfulness of proposed medical treatments when patients are not capable of consenting or have refused consent to such interventions

In cases of permanent vegetative states, the court's authority must be obtained before artificial nutrition and hydration is withdrawn

In other cases the courts can protect doctors from criticism and claims that they have acted unlawfully

In the case of adults, the legal criteria are whether patients lack the capacity to give or refuse consent, and if so what is in their best interests; in the case of children, welfare is the paramount consideration

Starting point

The starting point for lawyers and doctors alike is that intentionally touching a person is unlawful—the civil wrong of battery or even the crime of assault—unless that person has consented or there is other lawful authority. This applies to medical procedures even when carried out competently in other respects in accordance with established medical practice. There is a legal doctrine of necessity that provides lawful authority for emergency medical treatment that is both necessary and reasonable and is designed to save life, assist recovery, or ease suffering. Compulsory detention and treatment for mental disorder under the Mental Health Act 1983 have lawful authority if in accordance with, and subject to, the safeguards contained in that act. The House of Lords in the case of R versus Bournewood has extended the doctrine of necessity to cover treatment for mental disorder when there has been an informal admission to the hospital.[1] The case involving Ashworth Hospital and the moors murderer Ian Brady, who had decided to starve himself to death, is an example of a case in which the judge found that his refusal of food was a symptom, manifestation, or consequence of his mental disorder, and force feeding was therefore within the authority of that act. These circumstances are not further explored in this article.

Is there a need to go to court?

Most instances where medical treatment is given to save life or to enhance the quality of life take place without the need for any reference to the court. A patient with full capacity or parents on behalf of a child are in agreement with the doctors. When an adult

patient is disabled from giving consent, medical practitioners must act in that person's best interests, and if to improve or prevent deterioration in his or her physical or mental health requires major invasive surgery, they may carry it out. Indeed, if a patient is incapable of giving or refusing consent, either in the long term or temporarily (for example, owing to unconsciousness), there is a duty of care on the medical practitioner to treat the patient according to a judgment of his or her best interests.

The courts' intervention is justified in support of the doctors concerned when a declaration from the court (in relation to an adult) or an order (in relation to a child) will protect them and any others who may be concerned in the procedures from subsequent adverse criticisms and claims, including that they have acted unlawfully.[2] Conversely, the court is available to safeguard the welfare of a patient.

It has been decided in the leading case of permanent vegetative states (Airedale NHS Trust versus Bland) that where withdrawal of artificial nutrition and hydration that will result in death is proposed, a declaration from the court as to the lawfulness of the "positive" withdrawal should invariably be obtained.[3] In June 1999 the BMA published its *Guidance for Decision Making on Withholding or Withdrawing Life-Prolonging Medical Treatment*, in which it says that other situations in which life prolonging treatment is not a benefit to the patient should not routinely be subject to review by the courts.[4] It follows from our starting point that a passive "do not resuscitate" decision, which does not involve an assault, does not give rise to the same potential legal liability and therefore does not require the court's authority, although unless handled sensitively and in accordance with recommended practice, it may give rise to public concern (or form the basis for a negligence action).

Dealing with adults

Even when a patient's own life depends on receiving medical treatment, an adult of sound mind is entitled to refuse such treatment. This reflects the right of self determination. This is the overriding principle even where there is a fetus in the womb whose chances of being born alive or without injury equally depend on the adult's decision.[5]

Accordingly, the court's support for "authorising" invasive medical procedures is only forthcoming where it can be shown that the adult patient lacks the capacity to consent. The issue of capacity relies on whether the patient fully understands the nature of the interventions proposed, their reasons, and the consequences of submitting or not submitting to them. Lack of capacity may arise when he or she is unconscious or has mental disability. Because there is a different test under the Mental Health Act 1983, it does not follow that in every case in which a person is detained under that act, he or she lacks the capacity to consent to the medical treatment. *Guidance for Doctors and Lawyers on the Assessment of Mental Capacity*, which covers the different tests to be considered, has been jointly published by the Law Society and BMA.[6]

Consent may have been furnished in advance. Where a patient has given an advance directive of how he or she should be treated before becoming incapable, treatment and care should normally be subject to the advance directive. If, however, there is reason to doubt the validity or applicability of the advance directive—for example, it may sensibly be thought not to apply to the particular life threatening circumstances that have arisen—an application for a declaration may be made, and the court will consider the advance directive as a part of the evidence of what is in the patient's best interests.

Once lack of capacity is shown, the test is one of best interests. This has been judicially defined to encompass medical, emotional, and all other welfare issues. A court should draw up a checklist of the actual benefits and disadvantages and the potential gains and losses, including physical and psychological risks and consequences, and should reach a balanced conclusion as to what is right from the point of view of the individual who is the subject of the proceedings.[7]

The special position of 16-18 year olds

It is worth briefly mentioning the special position of 16-18 year olds, in that by virtue of section 8 of the Family Law Reform Act 1969 they are able to give consent to medical treatment as if they were adult. It does not, however, follow that if they refuse to give their consent and are on the face of it capable of making that decision, their refusal will be determinative in the same way as it would be if they were adult. No minor of any age has power by refusing treatment to override a consent given by the court or by a person having parental responsibility. The child's level of competence is relevant in assessing the weight to be given to his or her views, but these views will not determine the issue.[8] The paramount consideration is the welfare of the child.

Dealing with children

Where the patient is a child, consent to medical treatment can be given by those having parental responsibility—usually the parents. If the parents refuse consent to treatment recommended by the doctors, it will be necessary (and possible) for the consent to be supplied instead through an order of the court.

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Official solicitor Laurence Oates represented the siamese twins Mary and Jodie when the courts recently ruled they could be separated

Effectively there is a starting point that the united view of both parents is correct in identifying where their child's welfare lies. That will be cancelled out where the court finds on the evidence that their view is contrary to the welfare of the child—as in the case of the infant of an HIV positive mother where the judge found that it was overwhelmingly in the interests of the child that her parents and doctors caring for her should know whether she had contracted the virus.[9] Moreover, it is well established that, for example, although Jehovah's Witnesses may in accordance with their religious beliefs withhold consent to blood transfusions for themselves as adults, if their children's lives are endangered the courts will provide the missing consent for the administration of blood.[10–12]

When a child is able to express his or her own view, this becomes a factor in the decision about treatment. The courts have described a category of child as "Gillick competent"—that is to say of sufficient understanding and intelligence to understand fully the specific treatment proposed.[13] Such a finding does not, however, as noted in relation to 16-18 year olds, provide for the same autonomy and right of self determination as for an adult. A court may use its inherent jurisdiction to override the refusal of consent if satisfied that is what the welfare of the child requires.

Several cases concern teenage patients who refuse consent to treatment recommended by their doctors and who may thereby put themselves in a life threatening situation. The court may be called upon to resolve the tension between the child's own views and an objective assessment of his or her welfare. The cases referred to the courts have concerned young people whose competence was doubtful, and in these cases the courts have upheld the conclusion that where the lives of patients aged under 18 are in danger, they should not be allowed to bring about their own death however strong their objections to treatment. In such cases it is not only my duty as Official Solicitor to inform the court of the patient's views but to make recommendations taking account of those views and in accordance with broader considerations of welfare. A striking example of these principles is the case of the 15½ year old girl who was opposed to a heart transplant and yet whose future life and welfare depended on it.[14] In that case there was evidence of the girl's confused state of mind, understandably brought about by the overwhelming circumstances that had suddenly and unexpectedly arisen, and the judge decided the case on broad welfare grounds. This case is also an example of the NHS trust's perception that in the particular circumstances, although they had the parents' support for the doctors' proposal, in the light of the girl's known views and the nature of the treatment, an order from the court was needed.

Conclusion

In any case in which an NHS trust or other health provider needs to go to court, there are well established procedures to be followed.[15–17] Doctors need to be vigilant about whether there is any dispute or difficulty in relation to the treatment of any of their patients. This may arise over doubts about whether patients have the capacity to consent or where there is an issue as to what is in their best interests or welfare. It will have arisen where the person concerned or close members of the family object to the treatment proposed.

The cases I have described are examples of the working of these procedures and principles. The court deals with all such cases with the expediency they deserve. The evidence doctors are required to give depends on the nature of the issues and the extent to which there is any dispute. Once the principles of best interests (in the case of an adult without the capacity to consent) or welfare (in the case of a child) become the governing consideration, the courts will apply those principles in the light of the individual facts of each case.

Doctors who are likely to face these situations (or their hospital administrators) should have an easy means of contacting their lawyers. I operate an emergency hotline to ensure that I can assist in securing a speedy hearing of these issues by the court whenever they arise. This office cannot, however, advise doctors, as I am likely to be brought in to represent the child or adult patient.

Written and, preferably, sworn evidence will need to deal, where relevant, with the issue of consent and capacity to consent and in all cases cover the medical grounds for the course of action proposed. The court must be provided with accurate and all relevant information. This should include the reasons for the proposed treatment, the risks involved in the proposed treatment and in not proceeding with it, whether any alternative treatment exists, and the reason, if ascertainable, why the patient refuses the proposed treatment.

I will need to have had the opportunity, where applicable, to obtain the views of the patient and to make my own inquiries, including where appropriate obtaining my own medical opinion. In cases of permanent vegetative state, independent medical opinion needs to be obtained, supporting the diagnosis and termination of artificial feeding and hydration.

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1 R v Bournewood [1999] 1 Appeal Cases 458.
2 Re F [1990] 2 Appeal Cases 1, at p 56.
3 Airedale NHS Trust v Bland [1993] Appeal Cases 789, at p 859F.
4 *Guidance for decision making on withholding or withdrawing life-prolonging medical treatment.* London: BMJ Publishing, 1999.
5 St George's Healthcare NHS Trust v S [1998] 2 Family Law Reports 728.
6 *Guidance for doctors and lawyers on the assessment of mental capacity.* London: Law Society and BMJ Publishing, 1995.
7 A [2000] 1 Family Court Reports 193.
8 Re W (A Minor) (Consent to Medical Treatment) [1993] 1 Family Law Reports 1.
9 Re C (HIV Test) [1999] 2 Family Law Reports 1004.
10 Re R (A Minor) (Blood Transfusion) [1993] 2 Family Law Reports 757.
11 Re S (A Minor) (Medical Treatment) [1993] 1 Family Law Reports 376.
12 Re O (A Minor) (Medical Treatment) [1993] 2 Family Law Reports 149.
13 Gillick v West Norfolk and Wisbech Area Health Authority [1986] Appeal Cases 112.
14 Re M (Medical Treatment: Consent) [1999] 2 Family Law Reports 1097.
15 Practice Note (Official Solicitor: Sterilisation) [1996] 2 Family Law Reports 111.
16 Practice Note (Official Solicitor: Vegetative State) [1996] 2 Family Law Reports 375.
17 St George's Healthcare NHS Trust v S [1998] 2 Family Law Reports 728 at p 758.

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